BATTLE AND NON-BATTLE INJURY DOCUMENTATION: THE RESUSCITATION RECORD

Original Release/Approval		1 Jun 2008	Note: This CPG requires an annual review.			
Reviewed:	Dec 2013	Approved:	l: 05 Dec2013			
Supersedes: Battle Non Battle Injury Documentation Resuscitation Record 20 Sep 12			ation Record 20 Sep 12			
Minor Changes (or)		Changes are	e substantial and	l require a thorough reading of this CPG (or)		
Significa	nt Changes	Corrected referen	nces in the PI Mo	nitoring section.		

1. Goal. Obtain complete trauma documentation, including evacuation documentation, on all trauma patients from Role 2 and Role 3 within the CENTCOM AOR.

2. Background. The role of trauma documentation within the Joint Theater Trauma System for trauma performance improvement has continuously increased since the Joint Theater Trauma Registry (JTTR) was initiated in 2004. This progression is not unlike the first civilian trauma registries and standardized trauma flow sheets that were developed in the late 1980s. JTTR data acquisition and processing has improved greatly, partly because of the continuing advances (i.e., development of a standardized Resuscitation Record, formerly trauma flow sheet, initiation of Oracle-based registry database, and Level II Access trauma database) that offer new approaches and maximize computer technologies and the deployment of trauma coordinators to Role 3 sites. Data collection that allows theater-wide comparison is important for the continuous learning process and to improve outcomes, standard of care development, analysis of differences in the mechanisms of injury, rescue systems, and approved treatment guidelines.

Although Resuscitation Record documentation can incorporate information from numerous sources (nursing flow sheets, monitors, MEDEVAC run-sheets, I-stat print outs, etc.); if the history taking, physical examination, or decision making is not documented by the trauma team leader, it did not occur. Therefore, good documentation on the Resuscitation Record is most important for care of the individual patient and the system-wide delivery of trauma/critical care to all injured patients within the CENTCOM AOR. It is easy to forget or only capture limited data on the Resuscitation Record when trauma patients spend very little time in the ED prior to heading to the OR. However, it is imperative to document the thought process and to take the time to complete the Resuscitation Record when time permits, even if completed the next day.

Although trauma documentation requirements are well known, it is noted that this is an area in need of improvement. Although not exhaustive, the following are documentation performance improvement areas that repeatedly surface which need careful attention:

- a. Complete set of initial vital signs, including temperature and respiration rate
- b. GCS total score and individual Motor, Verbal and Eye opening scores
- c. Total IV volume (blood, colloid and crystalloid) infused in the ED, even if fluid administration continues after transport
- d. Disposition: Place and time

- e. Arrival time
- f. Mechanism of Injury
- g. Labs transferred to trauma flow sheet (especially HCT, INR, and BE)
- h. Lethal Triad Indicators (Hypothermia, Acidosis, Coagulopathy)
- **3.** Indications for Initiation and Completion of Resuscitation Record. A Resuscitation Record should be initiated on *ALL* patients (battle/non-battle injury coalition forces, ANA, ANP, LN, contractors, etc.) triaged as Immediate. In addition, Resuscitation Record should be completed on all patients seen within the first 72 hours following injury, including but not limited to the following injury causes:
 - a. Building Collapse
 - b. Bullet/GSW/Firearm
 - c. Burn
 - d. EFP
 - e. Fall
 - f. Fire/Flame
 - g. IED
 - h. Inhalation Injury
 - i. Mine
 - j. Mortar/Rocket/Artillery Shell
 - k. Multi-Frag
 - l. MVC
 - m. Sports
 - n. UXO
 - o. Other
 - p. All trauma admissions to any/all Role 3 facilities in the continuum

It is the intent of this guideline that the broadest definition of trauma be used. This should include the majority of patients with single or multi-system injury seen in the emergency department or admitted directly to the ICU and is to be used as the primary method of initial documentation.

- 4. Performance Improvement (PI) Monitoring.
 - a. Intent (Expected Outcomes).
 - 1) All patients in a US lead Role 2 or Role 3 facility have a Trauma Resuscitation Record complete and in the patient's record.
 - 2) Trauma Resuscitation Record Part I Nursing Flow Sheet has complete and accurate documentation from the primary survey in sections 3.1, 3.2, and 3.3.

- 3) Trauma Resuscitation Record has complete and accurate documentation in the patient identification section, i.e. patient name, patient ID/SSN, facility, nurse and provider.
- 4) Trauma Resuscitation Record Part II Physician H & P has complete and accurate documentation in sections 1.3, 1.5 and 6.3.
- b. Performance/Adherence Measures.
 - 1) All trauma patients triaged as immediate or with injuries sustained from one of the causes listed in section 3 had the trauma Resuscitation Record completed.
 - 2) The trauma Resuscitation Record was completed by the provider and the nurse on every patient expected to be admitted to a Role 3 or actually admitted to a Role 3 facility.
- c. Data Source.
 - 1) Patient Record
 - 2) Department of Defense Trauma Registry (DoDTR)
- d. System Reporting & Frequency.

The above constitutes the minimum criteria for PI monitoring of this CPG. System reporting will be performed biannually; additional PI monitoring and system reporting may be performed as needed.

The system review and data analysis will be performed by the Joint Theater Trauma System (JTTS) Director, JTTS Program Manager, and the Joint Trauma System (JTS) Performance Improvement Branch.

5. Responsibilities.

- a. It is the trauma team leader's responsibility to ensure the Resuscitation Record Part II, Physician H&P is complete at Role 2 and Role 3.
- b. It is the responsibility of the nurse assigned to the trauma bay/patient to ensure the Resuscitation Record Part I, Nursing Flow Sheet is completed at Role 3.
- c. A member of the trauma team that is receiving report (CCATT, medevac, ground ambulance) should request a copy of the transport run-sheet and ensure it is included in the patient's record. All times on the Resuscitation Record should be local 24-hour military format (hhmm).

Approved by CENTCOM JTTS Director, JTS Director and CENTCOM SG

Opinions, interpretations, conclusions, and recommendations are those of the authors and are not necessarily endorsed by the Services or DoD.

APPENDIX A	Resuscitation Record—Part I Nursing Flow Sheet, page 1 of 5
1	RESUSCITATION RECORD

	Pa		Nursing	g Flow She	et		
1. PATIENT INF	ORMATION				10000100000		
1.1 TRAUMA TEAM DAT	THE CONTRACT OF A CONTRACT OF	1.4 MO	DE OF ARRIVAL	1.6 INJURY		TENT CATEGORY	1.10 INJURY CAUSE
	ne Time	U Wal	ked/Carried	CLASSIFICATIO		SA	Building Collapse
The second se	led <u>Arrived</u> <u>Name</u>		SEVAC - Air	Battle			Bullet/GSW/Firearm
EDPhysician	10 - 186a		SEVAC - Ground	Non-Battle	-36		Bum
Trauma Surgeon			DEVAC - Air		U 🗆	SMC	EFP
Respiratory Therapy	<u>10 - 270</u>			CIRTIONIT	U U	SN	Fall
Anesthesiology		and a second second	ssion #	A T TOIL OF CATEGO		SCG	Fire/Flame
Lab/Blood Bank		ME ME	DEVAC - Ground	Comparison of the second se			
Radiology		M	ssion #	Imme diate	0 U	SPHS	
Pharmacy	14 E24		ATT	Delayed	C	vilian - Local	Inhalation Injury
and the second sec		D Shi	D EVAC	Minimal		vilian - Other	Mine Mine
Consult (i.e., Ortho)	- 18	AE		Expectant		ontractor	Mortar/Rocket/
1.2 ARRIVAL	1.3 EVAC FROM	- Course		1.8 VALUABLES			Artillery Shell
Date	1 st Responder	Ott Ott	ner	FOUND		200	Multi-Frag
Time of Arrival	Forward	1.5 INJU	RY TYPE	None		ATO - Coalition	MVC
Time of Injury	Forward Resuscitative Care		int	Given to Patier		on-NATO -	Sports
Date of Injury	Theater Hospital	Bu		Secured by PA	0	oalition	
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Transit Time minutes		Pe Pe	neclaung				
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2.1 PREHOSPITAL TOUR	NIQUET			3 PREHOSPITAL	2.4PREHO		6 PREHOSPITAL
Upper Extremities:	Lower Extremities:	VITA		ON TROL	WARMING		NTERVENTIONS
Type:	Type:	GCS	in N	MEASURES	Blanke	et P	Prehospital Airway
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Other	Other	Ve	Dal 15	Celox	HPMK	0	
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		00		QuikClot	0	10	
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many?2 [] 4 many? 2 2	4 BP -	— ' [Unknown			OD Y N
Effective? Y	N Effective? Y	N O2S	at	Other	22 10	C	PR
		266. j. –					prior to arrivalY
3. PRIMARY SU	RVEY						
3.1 VITALS	3.3 HYPO / HYPERTHERMIA CONT	ROL 3	5 BREATHING			3.6 CIRCULATIO	<u>DN</u>
Р	MEASURES	1	Unlabored	Breath So	unds:	Skin:	
RR	Arrival Temp F	c ľ	Labored	Clear		🗌 Warm 🔲	Cool Hot
<u> </u>	Time Date		Flaring			Pink	Pale Cyanotic
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O2Sat	Route Oral Axillary	necta	Absent			Heart Sounds:	
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	🔲 Bair Hugger 🔄 Warming Bl	anket	Thest Symmetry		chea:	Capillary Refill:	
3.2 AIRWAY	Fluid Warmer Cooling Bla		Equal L	eft > 🗌 Right > 🗌	Midline	< 2 Second	ls (normal)
Patent		1	lail 🗌 R 🛄	L 🗌	Deviated	> 2 Second	is (de layed)
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Intubated	Start Time	3			-		-
Combi Tube		[Responds to I	Painful Stimuli	Motor	/6	
	End Time	r	Un responsive	e to Painful Stimuli	Total	/15	
Other							
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Patient ID/SSN	BRN N	Aed ical Re	cord #	DOE	3	Age	Gender M F
Fadlity Name	Facility	ocation		MOS	AFSC/NEC	Deploye	ed/Assigned Unit
Nurse Name	. Jointy .		Nurses	ignature			
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	Resuscitati			<u> </u>			
		Part I,	Nursing Flo	ow She	et		
4. SECONDARY SU	1		1	10			
4.1 HEAD / NECK ENT Drainage: Nasal (Color) Ear (Color) Dental Injury Y CSF (Halo Test) + - C-spine Tender JVD Y Reactive Pupils Right: Y Brisk	4.2HEA Bhythm N N Tax V-f PEJ N PEJ N PEJ N PEJ N PEJ N PEJ Ott Pulses S = Str D = Do; Carotid Femora N Brachia	R chy/Brady ib/V-tach A ystole ong W = Weak ppler A = Absent I RL al RL	A.3 ABDOMINAL/GU Open Wound Flat Obese Distended Tender Rebound Tender Guarding Rigid Unable to Assess Pelvic Binder Blood at Meatus/Vagina FAST + describe Eventeed	mess [- - - - - - - - - - - - - - - - - - -	4.5 ALLERGIES	Image: Weight of the second	Y 🗌 N
		R L	Equivocal Last Meal @		8 <u>1</u>		
4.7 PROCEDURES					12		
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ET Intubation (Put additional changes in Remarks)	Time	Teeth	_ cm _ 0		¥¥	ETCO ₂ Change BBS Post Intubation	ĺ
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Chest Tube #1	Time			. 🗌 R	ii	Air Blood (cc)	
Chest Tube #2	Time		L	- 🗌 R		Air Blood (cc)	
Needle Decompression	Time		_ []	L 🗌 R	89 98	Air Blood (cc)	1002
Thoracotomy	Time	-		. 🗌 R Iamshell	s 		
Toumiquet	Time	Types	Sites		8 7		
Eye Shield	Time	<u></u>	os od	Both			
A-line	Time	20 - 20	L	. 🗌 R	2		
Gastric Tub e	Time	2 Z				Verified Y	
Urinary	Time	Amount Color Foley Size		Aeatus Suprapubic	8: 78	Heme Dip / [Results	
Other Procedure	Time	Describe					
Other Procedure	Time	Describe					
Hemorrhage Control Measures	Celox ChitoFlex	Combat Gauze	Field Dressing	QuikC		Unknown Dther	
PATIENTIDENTIFICATIO	Name: Last		First		MI	Patient ID/SSN	
BRN FacilityLog	tion	Nurse Name			Nurse Signature		
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Resuscitation Record—Part I Nursing Flow Sheet, page 2 of 5

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4. SECONDARY SU	RVEY, continue	AND A REAL PROPERTY A REAL PROPERTY AND A REAL	and the second					
4.8 INTUBATION MECH/VENT	4.9ABGs / VBGs							
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MODE:	ABG or VE	G		100				
FiO2:	ABG or VE	G	49					<u> </u>
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PEEP:	ABG or VE	G	(15)11	1833	-	505		· · · · ·
TV:		G		<u>1(6)</u>	325	<u>8</u> 94		<u>a 1</u>
4.10 INTRAVENOUS ACCESS	AND FLUIDS		4.11	BLOOD PRODUC	TS			
lime Rate Gauge	Site IVE Type /	Amount Up Amount	Un Stop Un 	it≝ Ixpe 			Volume	Initials
A 12 MEDICATIONS	Total Amount Infused:	Time Initials	4.13 VITAL SIGNS		 	emp SaO2	Pain Scale	2 Other (ICP)
		<u></u>		10	- 14			
4.14 LARS	15 CT							
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Time Test CBC [] ABG [] VBG [] Chemistry [] PT/PTT [] TEG *S H&H th	Type Time Head - C-Spine - Chest - Abd - Pelvis - Pan Scan* - elect Pan Scan <u>cnly</u> if all of e above requested	Admit OR C. K. BID Full Q. RTD Unit: RTD Mode of Trar Ambulat 4.18 DEATH INFORM Time of Death	Time:	- <u>Evac Pri</u> <u>Evac Tra</u> MEDI Groun	Facility Name:_ <u>ority</u> Routin <u>nsport Vehicle</u> VAC: Rotary' Fixed W nd: Medica <u>ode of Transport</u>	Wing - Mee Wing - Mee Ving - AE I Noi Ambulate Litter	ity Ur dTech C C n-Medical ory W Vacuum	gent ritical Care CATT /C
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Resuscitation Record—Part I Nursing Flow Sheet, page 3 of 5

	2073 (BH () 2073 (ION RECORD /sician H&P
1. HISTORY & PHYSICAL - IN			
1.1 ARRIVAL	1.2 TRIAGE CATEGORY	1.4 INJURY DESC	BIPTION
Date	Immediate Delayed Minimal Expectant	(AB)rasion (AMP)utation (AV)ulsion (BL)eeding (B)urn %TBSA	R L L R S= Strong W= Weak D= Doppler
1.3 CHIEF COMPLAINT, HISTORY AND		(B)urn % 185A (C)repitus (D)eformity (DG)Degloving (E)cchymosis (FX)Fradure (F)oreign Body (GSW)Gun Sho (H)ematoma (LAC)eration (PW)Puncture V (SS)Seatbelt Sii (SW)Stab Wour (P)ain (PP)Peppering	t Wound gn id
	4		ANTERIOR POSTERIOR
<u>1.5 HISTORY AND PHYSICAL</u> Head & Neck:			1.6PRE / INITIAL PROCEDURES / DIAGNOSTICS Pre / Initial Cric C-Collar/ Time Removed Image: Initial I
<u>Chest:</u>			Needle Decompression R L Pericardial describe: Output Air Blood (cc) Pericardiocentesis +
Abdomen/Back and Spine:			DPI. Gross Blood: - / + describe Log Boll Time
Pelvis: Stable	Unstable 🗌 Binde	r	Prostate Gyn
Upper Extremities:			Closed Reduction EXT Fixation Tourniquet R # Wound Washout Splint L #
Lower Extremities:			Closed Reduction EXT Fixation Tourniquet R # Wound Washout Splint L #
Interventions Prior to Arrival:			Sedated 3% Saline Cntrl Line Loc Site Chemical Paralyze Mannitol IO Loc Site Seizure Protocol A-Line Loc Site
1.7 PUPILS / VISION Brisk R L Brisk R L Sluggish R L NR R L NR R L Size Right mm Left mm	□ R □ L □ tion □ R □ L %π teption □ R □ L >20	% Use the Burn Flow	RUE + / + / + / + /
PATIENT IDENTIFICATION Na	me: Last		First MI Rank
	NUMBER OF STREET	al Record #	DOB Age Gender M F
Facility Name	Facility Location		Physician Signature
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Resuscitation Record—Part II Physician H &P, page 4 of 5

	TATION RECORD , Physician H&P	
2. X-RAYS and CT		
2.1 CT OBTAINED 2.2X-RAYS OBTAINED 2.3 PENDING STUDIES	2.4 RESULTS (include TEG/Rotem results)	2.5 C-SPINE RESULTS
Head C-Spine Extremity	······································	CT Scan Normal
C-Spine Spine RUE		CT Scan Abnormal
Chest Chest/Upright LUE		C-Spine cleared based on:
		Normal Exam, reliable Pt
Abd/Pelvis Pelvis RLE		Normal CT scan, normal exam
Pan Scan*		C-Spine not cleared based on: Neuro c/o, abnormal exam
* Select Pan Scan only if all of the Other		
above requested Other		Unreliable Pt
3. LABORATORY RESULTS		
3.1 CBC 3.2 CHEMISTRY 7	3.4 LFT	3.5 URINALYSIS
	Contractor of the Second	MARTINESS CONTRACTOR
	Amylase Bili	SpGr Chem
	Alk Phos SGOT	Migro HCG
	LDH SGPT	pH Bact
		- Contra Di Cont
3.3 PT / INR / PTT / /	Other	_ WBC RBC
4. IMPRESSION	10	
1 2 3 6. PLAN	4 5 6	
6.1 PLAN		
6.1 PLAN		
6.1 PLAN 6.2 TRIAD INDICATORS UPON ARRIVAL IN ED		
6.1 PLAN 6.2 TRIAD INDICATORS UPON ARRIVAL IN ED Temp < 96F/36C Yes No	Base Deficit >5 🗌 Yes 📄 No 🛛 Dan	nage Control 🗌 Yes 📄 No
6.1 PLAN 6.2 TRIAD INDICATORS UPON ARRIVAL IN ED Temp < 96F/36C	Base Deficit >5 🗌 Yes 📄 No 🛛 Dan	nage Control 🗌 Yes 📄 No
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Resuscitation Record—Part II Physician H &P, page 4 of 5

APPENDIX B General Instructions for Resuscitation Record, Page 1 of 5

General Instructions for Resuscitation Record

Purpose: The Resuscitation Record is for documenting a trauma patient's injuries and related medical treatment and resuscitation care provided at DoD medical treatment facilities (MTFs). It is to be used at all DoD MTFs which have a surgical capability or emergency department (ED). A trauma patient is defined as a person who has an injury with the potential of requiring a surgical intervention. The form is comprised of two parts. Part I, Nursing Flow Sheet is completed by the nurse fulfilling the role as a scriber or the nurse providing bed side care. Part II, Physician H&P (History and Physical) is completed by the trauma physician providing care for the patient. The Resuscitation Record becomes part of the patient's permanent DoD medical record.

PART I, NURSING FLOW SHEET

General Instructions:

- To be completed by the nurse fulfilling the role as a scriber or the nurse providing bed side care.
- Time Zones: Record all time local 24 hour military format, hh:mm
 - A+ (plus sign) means positive test result; a (minus sign) means negative test result.

PATIENT IDENTIFICATION (at bottom of each page). As stated.

FACILITY NAME. Record your MTF unit identifier

FACILITY LOCATION. Record FOB, COB, or geographic site

BRN. Battle Roster Number

MOS. Military Occupational Specialty

AFSC. Air Force Specialty Code

NEC. Navy Enlisted Classification

1 PATIENT INFORMATION

- 1.1 TRAUMA TEAM DATA. As stated. Record all time local 24 hour military format, hh:mm
- 1.2 ARRIVAL. As stated.
- 1.3 EVAC FROM. Check all that apply. Location is the facility name.
- 1.4 MODE OF ARRIVAL. Check one. MEDEVAC Air includes DUSTOFF. If Other, describe the method by which the patient arrived, such as PJ or MERT, but not DUSTOFF.
- 1.5 INJURY TYPE. Check all that apply.
- 1.6 INJURY CLASSIFICATION. Check one.
- 1.7 TRIAGE CATEGORY. Check one.
 - Immediate Patients who require rapid, immediate intervention in order to preserve life and/or limb AND are likely to survive because of the intervention--damage control surgery (ex: respiratory obstruction, unstable casualty with chest or abdominal injuries, uncontrolled hemorrhage, hypovolemic shock, emergency amputation)
 - Delayed Patients who require surgery or other specific therapeutic intervention, but who will not be severely compromised if the intervention is delayed to a later time (ex: closed fx without neurovascular compromise, moderate burns of < 50% TBSA, large muscle wounds, intraabdominal and/or thoracic wounds)
 - Minimal Non-Urgent: Minor Injuries; patient can safely care for themselves or be helped by nonmedical personnel. (ex: Minor lacerations, abrasions, fractures of small bones, and minor burns). Can safely wait 12-24 hours or longer for care.
 - Expectant Patients whose injuries are so severe that even with the benefit of optimal medical resources, their survival would be unlikely (ex: massive open head injury with brain matter present, high spinal cord injuries, mutilating explosive wounds involving multiple anatomical sites and organs, second/third degree burns in excess of 60% TBSA, profound shock with multiple injuries and agonal respirations)
- 1.8 VALUABLES FOUND. Check one. Time correlates to checked item.

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General Instructions for Resuscitation Record, Page 2 of 5

	General Instructions for Resuscitation Record
1.9	PATIENT CATEGORY. Check one. If Other, describe the patient's classification as it relates to military, government or civilian organizations. USA. United States Army
	USAF, United States Air Force
	USMC. United States Marine Corp
	USN. United States Navy
	USCG. United States Coast Guard
	USPHS, United States Public Health Services
	Civilian – Local, Includes Host Nation.
	Civilian – Other, Includes Host Nation Police
	EPW. Enemy Prisoner of War
	NATO-Coalition. Joining military forces
	Non-NATO Coalition. Opposing military forces
	Other. Describe not otherwise specified category.
1.10	
1.10	EFP. Explosively Formed Projectile/Penetrator
	IED. Improvised Explosive Device
	Mortar/Rocket/Artillery Shell. Includes Indirect and Direct Fire
	MVC. Motor Vehicle Crash
	UXO. Unexploded Ordnance
2	CARE DONE PRIOR TO ARRIVAL
2.1	PREHOSPITAL TOURNIQUET. Check all that apply.
	SOFTT. Special Operations Forces Tactical Tourniquet
	CAT. Combat Application Tourniquet
	If Other. Describe the type of tourniquet.
	Effective. An effective tourniquet controls active hemorrhage. May be combined with a dressing.
2.2	PREHOSPITAL VITALS. As stated.
2.3	PREHOSPITAL HEMORRHAGE CONTROL MEASURES – Check all that apply. Celox. Granules, applicator or gauze. Stops bleeding by bonding with red blood cells and gelling with fluids to produce a sticky pseudo clot. This clot sticks to moist tissue to plug the bleeding site. Celox is made with chitosan, a natural polysaccharide.
	ChitoFlex. A stuffable wound dressing conducive to narrow wound tracks.
	Combat Gauze. Combat Gauze™ is a 3-inch x 4-yard roll of sterile gauze. The gauze is impregnated with kaolin, a material that causes the blood to clot.
	Direct Pressure. Pressure applied directly to a wound, usually with sterile, low-adherent gauze between the wound and source of bleeding.
	Field Dressing. A casualty's dressing applied to a wound to control hemorrhaging.
	HemCon. Bandage or patch that becomes sticky when in contact with blood, seals the wound and controls the bleeding. HemCon products are made from chitosan, a naturally occurring, bio-compatible polysaccharide.
	QuikClot. Emergency dressing, combat gauze, interventional bandage, QuikClot ACS+™, QuikClot 1st Response™. When QuikClot [®] comes into contact with blood in and around a wound, it takes in the smaller water molecules from the blood. The larger platelet and clotting factor molecules remain in the wound in a concentrated form. This promotes rapid natural clotting and prevents severe blood loss.
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General Instructions for Resuscitation Record, Page 3 of 5

 includes non-palpable, but detected with Doppler. Absent means no pulse, non-palpable and not detected with Doppler. ALLERGIES. Check one. NKDA is No Known Drug Allergies. If Other, describe not otherwise specified allergy. CURRENT MEDICATIONS. As stated. Current Meds. List medication, dose and route. 		Gene	ral Instructions for Resuscitation Record
If Other, describe the not otherwise specified hemorrhage control measure. PREHOSPITAL WARMING. Check all that apply. HPMK. Hypothermia Prevention and Management Kit. Check only if all three components were used: Hat/Hood, Activated Liner, and Outer Shell. If Other. Describe the not otherwise specified warming device. 25 PREHOSPITAL MEDS. Enter medication, dose and route. 26 PREHOSPITAL INTERVENTIONS. As stated. 3 PRIMARY SURVEY 11 VITALS. As stated. For Pain Scale, enter level that patient indicates their pain to be. Zero indicate the least pain; 10 is the most severe pain. 3.1 AIRWAY. As stated. If Other, describe the not otherwise specified type of airway. 3.2 AIRWAY. As stated. If Other, describe the not otherwise specified type of airway. 3.4 CPR IN ED. As stated. 5 BERATHING. As stated. 6 CIRCULATION. As stated. 7 DEFICIT/NEURO. As stated. 8 Color Patient Weight 6 Greevine/Weight 9 Green 30 - 35 Kg 4 SECONDARY SURVEY 11 HEAD/NECK ENT. As stated. 12 HEART / THORACIC. Reviewere/Wright/feure/Velow 8-14 Kg		None. Check if no hem	orrhage control measures.
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General Instructions for Resuscitation Record
4.10 INTRAVENOUS ACCESS AND FLUIDS. As stated.
4.11 BLOOD PRODUCTS. As stated. Initials. Legible initials of person who performed task.
4.12 MEDICATIONS. As stated. Initials. Legible initials of person who performed task.
4.13 VITAL SIGNS. As stated.
4.14 LABS. Enter time as stated.
4.15 CT. As stated.
4.16 X-RAY. As stated.
4.17 DISPOSITION. As stated.
4.18 DEATH INFORMATION. If death, as stated. Leave blank if patient is alive.
4.19 REMARKS. Enter additional information relevant to the patient's nursing care.
PART II, PHYSICIAN H&P
General Instructions:
 To be completed by the trauma physician providing care for the patient. Time Zones: Record all time local 24 hour military format, hh:mm A+ (plus sign) means positive test result; a - (minus sign) means negative test result.
PATIENT IDENTIFICATION (at bottom of each page). As stated.
FACILITY NAME. Record your MTF unit identifier
FACILITY LOCATION. Record FOB, COB, or geographic site
BRN. Battle Roster Number
1 HISTORY & PHYSICAL – INJURY DESCRIPTION
1.1 ARRIVAL. As stated.
1.2 TRIAGE CATEGORY. Check one. Refer to 1.7 for definitions from Part I Nursing Flow Sheet.
1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS. As stated.
1.4 INJURY DESCRIPTION. As stated. Doppler includes non-palpable, but detected with Doppler. Absent means no pulse, non-palpable and not detected with Doppler.
1.5 HISTORY AND PHYSICAL. As stated. Interventions Prior to Arrival is any intervention performed a prehospital or transferring facility.
1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS. As stated. Pre means prior to arrival. Cntrl Line is Central Line.
1.7 PUPILS/VISION. As stated.
1.8 BURN. As stated. Describe the cause of burn.
1.9 EXTREMITIES. As stated.
2 X-RAYS AND CT
2.1 CT OBTAINED. As stated.
2.2 X-RAYS OBTAINED. As stated.
2.3 PENDING STUDIES. As stated.
2.4 RESULTS. Include TEG/Rotem results.
2.5 C-SPINE RESULTS. As stated.
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General Instructions for Resuscitation Record, Page 5 of 5

APPENDIX C

ADDITIONAL INFORMATION REGARDING OFF-LABEL USES IN CPGs

- **1. Purpose**. The purpose of this Appendix is to ensure an understanding of DoD policy and practice regarding inclusion in CPGs of "off-label" uses of U.S. Food and Drug Administration (FDA)–approved products. This applies to off-label uses with patients who are armed forces members.
- 2. Background. Unapproved (i.e., "off-label") uses of FDA-approved products are extremely common in American medicine and are usually not subject to any special regulations. However, under Federal law, in some circumstances, unapproved uses of approved drugs are subject to FDA regulations governing "investigational new drugs." These circumstances include such uses as part of clinical trials, and in the military context, command required, unapproved uses. Some command requested unapproved uses may also be subject to special regulations.
- **3.** Additional Information Regarding Off-Label Uses in CPGs. The inclusion in CPGs of off-label uses is not a clinical trial, nor is it a command request or requirement. Further, it does not imply that the Military Health System requires that use by DoD health care practitioners or considers it to be the "standard of care." Rather, the inclusion in CPGs of off-label uses is to inform the clinical judgment of the responsible health care practitioner by providing information regarding potential risks and benefits of treatment alternatives. The decision is for the clinical judgment of the responsible health care practitioner within the practitioner-patient relationship.

4. Additional Procedures.

- a. Balanced Discussion. Consistent with this purpose, CPG discussions of off-label uses specifically state that they are uses not approved by the FDA. Further, such discussions are balanced in the presentation of appropriate clinical study data, including any such data that suggest caution in the use of the product and specifically including any FDA-issued warnings.
- b. Quality Assurance Monitoring. With respect to such off-label uses, DoD procedure is to maintain a regular system of quality assurance monitoring of outcomes and known potential adverse events. For this reason, the importance of accurate clinical records is underscored.
- c. Information to Patients. Good clinical practice includes the provision of appropriate information to patients. Each CPG discussing an unusual off-label use will address the issue of information to patients. When practicable, consideration will be given to including in an appendix an appropriate information sheet for distribution to patients, whether before or after use of the product. Information to patients should address in plain language: a) that the use is not approved by the FDA; b) the reasons why a DoD health care practitioner would decide to use the product for this purpose; and c) the potential risks associated with such use.